

Management of personal health record content

Scope	This policy provides guidance on managing the content of personal health records.
Definition of terms	<ul style="list-style-type: none">• Designated record set—A group of records a HIPAA-covered healthcare provider maintains that includes medical records and billing records about individuals. The covered entity maintains and uses the designated record set, in whole or in part, to make decisions about individuals. (HIPAA CFR §164.501)• Electronic health record—<A specifically designed system that collects individually identifiable health information from multiple sources and supports healthcare users with available, complete and accurate data, practitioner reminders and alerts, clinical decision support systems, links to bodies of medical knowledge, and other aids.¹ >• Legal health record—“A subset of the entire patient database . . . and of the designated record set. . . . It is generated as the healthcare organization’s business record and is the record that will be disclosed upon request. It does not affect the discoverability of other health information by the organization. . . . It contains individually identifiable data, stored on any medium, and collected and directly used in documenting healthcare or health status. . . . It must meet accepted standards as defined by the Centers for Medicare & Medicaid Services’ Conditions of Participation, federal regulations, state laws, standards of accrediting agencies, as well as the policies of the healthcare provider.” (AHIMA²)• Patient portal—<A Web site or service that offers an array of resources and services to patients. Services may include general information about the healthcare organization, health education material selected by the healthcare organization and generally available to the public, merchant services for purchasing products, and secure e-access to services of the organization, such as

¹ Dick R.S., E.B. Steen, D.E. Demeter. *The Computerized Patient Record: An Essential Technology for Health Care*, Revised Edition, Washington, DC: National Academy Press, 1997, p. 47.

² Op Cit, AHIMA e-HIM Personal Health Record Work Group. “The Role of the Personal Health Record in EHR.” *Journal of AHIMA* ,76, no.7 (July-August 2005): 64A-D.

appointment scheduling, viewing diagnostic studies results, conducting e-visits, etc.>

- Personal health record—<A compilation of health information that an individual owns, maintains, and uses exclusively as a resource of health information to make health decisions.>

<An electronic, lifelong resource of health information for individuals and others to whom the individual provides access. It is also used to make health decisions.>

<An electronic resource maintained by the healthcare organization that enables individuals to securely access and enter health information about themselves.>

- System of health information—<The universe of individually identifiable health information that the healthcare organization maintains. It may include the designated record set, the legal health record, and other individually identifiable health information that the healthcare organization creates and maintains in any form, and it accepts content from a personal health record.>

Policy statement

- *Personal health records are valuable aids for individuals to use to maintain health information about themselves and to make personal healthcare decisions.* Residents have a right to review the content of their medical record in a reasonable format and time frame. Residents are also able to request that their health information record be amended. Residents wishing to amend their record, should make such request to the facility Administrator in writing. Appropriate documents should be provided to support the request.